HENDRICK
HEARING HEALTHCARE

Sound advice about your hearing

CHILD CASE HISTORY

Patient Name: _____ DOB: _____ Age: _____

1. Were there any problems during pregnancy or delivery? (Yes) (No)
2. Has your child had any medical problems since birth? (Y) (N)
   Describe: _____
3. Do you feel your child has a speech problem? (Y) (N)
   Describe: _____
4. Do you feel your child has a hearing problem? (Y) (N)
   Describe: _____
5. Has your child had more than 3 ear infections? (Y) (N) ( ) right ( ) left
6. Has your child ever had ear surgery or tubes? (Y) (N) ( ) right ( ) left
   When?_____
7. Was anyone in your family born with a hearing loss? (Y) (N)
8. What hospital was your child born at?_____

AUTHORIZATION FOR CARE: I grant permission to the employees of Hendrick Hearing HealthCare to render care to this patient and to carry out the orders of the attending physician, including consultants associated and assistants of choice.

FINANCIAL RESPONSIBILITY: I understand that I am responsible for the total charges for services rendered and I agree that all amounts are due and payable to Hendrick Hearing HealthCare upon receipt of services.

AUTHORIZATION TO RELEASE INFORMATION: I authorize Hendrick Hearing HealthCare to release any medical or other information requested by representatives of local, state or federal agencies; insurance companies; review agencies; or other organizations or entities as may be required for payment of claims which are due to Hendrick Hearing HealthCare as a results of this visit.

Name: _____ Date: _____

1934 Hickory Abilene, Texas 79601-2316 325-670-2134 1-800-259-4327 Fax: 325-670-4390

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Today's Date:_____

Patient's Name:_____DOB:_____Age:_____Sex:_____

Address_____

City:_____State:_____Zip:_____

SS#_____Home Phone#_____Cell Phone#_____

Place of Employment_____Employment phone:_____

REFERRED BY: Phone Book Friend Newspaper Physician Other (Please circle one)

Guarantor information (Person responsible for payment)

Guarantor's name:_____

Address:_____

Employer:_____Work Phone:_____

DOB:_____SS#_____

Insurance Company_____Group #:_____

Insurance ID #:_____

Next of Kin Not Living with Patient

Name:_____Relationship:_____

Address:_____Phone#:_____

REFFERRING DOCTOR:_____Phone#:_____

Are you a First Choice Member? (Y) Please present card (N)

I understand that my insurance will be filed as a courtesy to me and that I will be responsible for any deductible and/or co pay.

Patient signature:_____Date:_____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTIES

EFFECTIVE JANUARY 1, 2008

Your name and signature on this form indicate that you have received or have inspected a copy of Hendrick's Notice of Privacy Practices, effective April 14, 2003 on the date indicated below.

If you have any questions regarding the information set forth in this Notice of Privacy Practices, please do not hesitate to contact the Privacy Office at 325-670-7763.

I hereby give my permission to Hendrick Hearing Healthcare to discuss my healthcare with the following person (s):_____.

Printed name of Patient	Signature of Patient	Date
_____	_____	_____
Signature of Patient Representative	Relationship to Patient	Reason Patient Unable to sign
_____	_____	_____

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